Southeastern Sleep Center

Anthony Ackerman, MD · Galina Bogorodskaya, MD · Jorge Camacho, MD
Larissa Lim, MD · Joseph Tonner, MD · Kraiyuth Vongxaiburana, MD

Patient Name: ____ **Age:** ______ **Date:** _____________

Main Problem -
Please describe the main problem you are having regarding your sleep: ____________________________________

____

Sleep Questionnaire –
Duration of Symptoms ____

Factors that make symptoms worse or better____

Medications taken at bedtime: ____

Bedtime on weeknights: ________________ Bedtime on weekends: _________________

Wake-up Time weekdays: ______________ Wake-up time weekends: _______________

How long does it take to fall asleep?

____

Do you wake up at night? Yes No If yes, how many times and why? ______________________________

____

Do you nap during day? Yes No If yes, for how long? ____________________________

Is your sleep refreshing? Yes No Leg cramps? Yes No Restless legs at night? Yes No

Do you snore? Yes No If yes, how loud? _______________________________

Do you feel sleepy during the day? ____

Has anyone ever witnessed you stopping your breathing? ____

Has your weight changed over the past few years? If so, how? ____

Do you ever suddenly fall asleep or have full body weakness when you hear a funny joke or have extreme emotions?

____

Do you have morning headaches?	Yes	No	Do you have morning dry mouth?	Yes	No
Do you gasp or choke during sleep?	Yes	No	Do you have crawling feelings in legs at sleep onset?	Yes	No
Do you talk in sleep?	Yes	No	Do you sleepwalk?	Yes	No
Do you fall asleep unexpectedly?	Yes	No	Do you fall asleep while driving?	Yes	No
Do you have Nightmares?	Yes	No	Do you have leg kicks?	Yes	No
Unusual behaviors during sleep?	Yes	No	If so, what? ____________________		

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Medical History-
Please check any disease or condition you have had in the past or have now:

- ☐ High blood pressure ☐ Diabetes ☐ Heart disease ☐ Arthritis
- ☐ Asthma ☐ Glaucoma ☐ Heart attack ☐ Anemia
- ☐ Lung Disease ☐ Liver disease ☐ Thyroid disease ☐ Gout
- ☐ Kidney failure ☐ Acid reflux/ulcers ☐ Fibromyalgia ☐ Migraines
- ☐ Kidney stones ☐ Seizures/Epilepsy ☐ Depression ☐ Anxiety
- ☐ High cholesterol ☐ Muscle disease ☐ Psychiatric disease ☐ Neuropathy
- ☐ Cancer (where? ______________ When? ___________ therapy _________________)

Please list any other health problems not described above or describe above condition further: ____________________

____

Surgical History-
Please list any surgeries you have had and the approximate dates: ____

____
____

Current Medications: Please provide a list of your medications or write them here

Name	Strength (mg)	# of Tablets	# of Times Per Day

What over the counter medications or remedies do you take? ____

____

List/describe any "alternative" or "complementary" therapies you are receiving: ___________________________

____

Medication allergies: ____

____

SIMED
SOUTHEASTERN INTEGRATED MEDICAL

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Patient Name: ____ **Age:** ______ **Date:** _____________

Family History –

Relative:	Father	Mother	Sister(s)	Brother(s)	Child(ren)
Age (if living)					
Cause / Age at time of death					
Cancer					
Seizures					
Stroke					
Heart Attack					
Migraines					
Diabetes					
Psychiatric Illness					
High Blood Pressure					
Sleep Apnea					
Narcolepsy					
Restless Leg Syndrome					
Others, Write In					

Social History –

Do you smoke?

□ No Did you ever smoke? Yes No If so, how much? _______ How long? ______ When did you quit? ________

□ Yes How much per day? ________ For how many years? ________

How much caffeine do you drink/day? ____

What time do you stop drinking caffeine? _____________________________________

How much alcohol do you drink? ____

Do you drink alcohol at bedtime? ____

Family- □ Single □ Married □ Divorced □ Widowed □ Significant other

Children – How many? ________ What are their ages? ___________________________

Occupation: ____

Education level (how far did you go in school?): ________________________________

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Review of Systems: Please check symptoms you have had in the past 3 months.

Constitutional

- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Recurrent Fevers
- ☐ Night Sweats

HEENT

- ☐ Severe headaches
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of hearing
- ☐ Ringing in the ears
- ☐ Difficulty swallowing
- ☐ Difficulty chewing
- ☐ Pain in jaw with chewing
- ☐ Change in voice / speech
- ☐ Head injury with loss of consciousness
- ☐ Flashing light in the eyes
- ☐ Brief loss of vision in one eye
- ☐ Wake up with dry mouth / headache

Cardiorespiratory

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Unusual cough
- ☐ Palpitations
- ☐ Coughing up blood
- ☐ Wake from sleep gasping

GI

- ☐ Abdominal pain
- ☐ Chronic diarrhea
- ☐ Chronic constipation
- ☐ Loss of bowel control
- ☐ Nausea / vomiting
- ☐ Blood in stool

GU

- ☐ Loss of bladder control
- ☐ Sexual difficulties
- ☐ Menstrual problems
- ☐ Frequent urination at night

Musculoskeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle cramping/stiffness

Endocrine

- ☐ Tendency to fatigue easily
- ☐ Unusual thirst
- ☐ Urinating often
- ☐ Intolerant of cold
- ☐ Intolerant of heat
- ☐ Hair loss

Hematologic

- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Frequent infections

Neuropsychiatric

- ☐ Numbness of arms/legs
- ☐ Weakness of legs / arms
- ☐ Vertigo / spinning feeling
- ☐ Tremors / Shaking
- ☐ Difficulty walking
- ☐ Language problems
- ☐ Memory loss
- ☐ Passing out
- ☐ Poor coordination
- ☐ Slowness of movements
- ☐ Depressed mood
- ☐ Nervousness/anxiety
- ☐ Hallucinations